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STRENGTHENING FINANCIAL MANAGEMENT CAPABILITIES IN THE UKRAINE

Odessa & Kodyma, Ukraine

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1.0 Summary

This trip report summarizes financial management technical assistance under Task Order 324 accomplished between June 10th and August 30th, 1996. The field work was accomplished in two phases and was directed at strengthening the financial management at three (3) intensive demonstration site (IDS) facilities. This task was an application of previously provided training in financial management and was directed at:

- The Odessa Clinical Hospital located in Odessa - 1120 beds
- The Odessa Municipal Hospital #10 located in Odessa - 680 beds
- The Kodyma Rayon Hospital located in a northern rural area of the Odessa Oblast - 575 beds

In the course of completing this task it became apparent that other facilities and organizations were interested in this type of assistance. On the request of IDS Site Manager Wittenberg, the work was materially expanded to include a concurrent roll-out of selected aspects of the current technical assistance to:

- The Odessa Oblast Health Administration - managing 19 institutions
- The Odessa Municipal Health Administration - managing 65 institutions
- The Family Health Center (FHC) in Odessa
- The Self-Financing Clinic (SFC) in Odessa

The following summarizes specific milestone activities that resulted from the field work.

Summary Chart of Milestone Activities

Activity
1. Decentralized budgeting methods rolled-out to Kodyma, a rural hospital, and help used to support a strategic initiative to cut 300 beds and 300 employees: Head Doctor using financial management tools to support proposed operational reorganization in order to financially survive. This increases the intensity of resources being applied to each occupied bed or patient visit. A total of 145 beds have been reduced to date as well 45 staff.
2. Automated decentralized budgeting methods, computer technology, and training "rolled out" to the Oblast Health Administration and the Odessa Municipal Health Administration. This provides the capability to more efficiently produce alternative scenarios for resource allocation among facilities across the Oblast and City of Odessa. The Oblast Authorities were particularly interested in this effort from a financial management perspective. The Municipal Authorities were interested in the effort from a computerization perspective.
3. Oblast Clinical Hospital in Odessa defined and then aligned strategic priorities with the automation process of selected financial management systems. This allowed for the rapid implementation of essential financial planning and cost management capabilities, focused management attention on key operational concerns, and provided labor savings to the accounting and administration departments. Key to the effort, was the technical assistance that was provided relating to strategic planning and managing organizational change in a prioritized manner.
4. Cost accounting functions "roll-out" to primary IDS Sites. A total of 13 departments produced service level costs across 3 institutions. This provided an ample demonstration of the task involved in calculating service level costs. The effort was also automated allowing for easier ongoing maintenance and cost update for service level costs setting the foundation for determining service costs in a more efficient and consistent manner.
5. Decentralized budgets were provided in three institutions and demonstrated before the Oblast and Municipal Authorities. Decentralization encourages more active participation by lower-level personnel, those actually responsible for providing services. Department

	level budgeting is a necessary step for decentralizing management authority and producing cost accounting data. Additionally, it is felt that those directly responsible for implementing a specific activity or program often have the best knowledge for identifying ways to allocate resources more efficiently. Better plans can be made and achieved when department managers become more fully involved in the budget planning of their department.
6.	Oblast Clinical Hospital automated selected aspects of its performance management function. Automation incorporated key performance indicators for senior management and offers the opportunity to link performance with staff incentives. The same ability was provided to the other two IDS sites, however, it appears the Oblast Clinical Hospital is best positioned to incorporate such techniques within their organization.
7.	Pragmatic computer training provided at all three IDS sites with focus on applying spreadsheet and database technology for financial analysis.
8.	<p>Integrated cost accounting information for improved internal controls at Municipal Hospital #10, Kodyma, and Odessa Clinical: RVU costs reconciled easier than bottom-up cost calculations. The value of this includes:</p> <p><i>Planning</i> - Cost accounting information can provide long and short term planning tools for financial and operational forecasting and budgeting, investment and divestment decision analysis, funding/pricing decisions, cost-volume-profit analysis break-even analysis and more.</p> <p><i>Organizing & Implementing</i> - Cost accounting facilitates the organizing activities of managers by helping to quantify the resources required to implement management plans and contribute important insight into the control of costs during ongoing operations.</p> <p><i>Control</i> - Cost accounting information provides measurement mechanisms which inform managers as to how they are doing compared to a planned or anticipated performance level. Effective and efficient control over resource consumption is only as good as the available information that managers use to assess, correct and improve operations.</p> <p><i>Leading and Communicating</i> - A major role of cost accounting information is to promote improved organizational leadership and communication. The planning tools described above as well as the techniques for providing more meaningful mechanisms for controlling and improving operations promote enhanced management decision making regarding how best to guide an organization into the future.</p>

1.1 Background of Field Work

The basis for this work began under Task 053 in February of 1996 when Else/Wouters taught a *Financial Management Workshop* in both Odessa and Lviv. Both workshops were well received by attending Ukrainian policy makers, hospital and polyclinic management, and other clinical and economic management personnel. The tools and techniques presented in this workshop highlighted pragmatic concepts of financial management for hospital and polyclinic managers in the Ukraine. These issues included techniques for basic budgeting, including decentralized budgeting and performance reporting, the production of cost accounting information when limited by a generalized financial accounting system and marginal, if any, computer capabilities, the establishment of systems of internal control, and more. In addition to the workshop, Else/Wouters wrote a manual¹ detailing the techniques and experiences discussed in the workshops and noted many of the fieldwork experiences to date. This training workshop was complemented by a follow-on workshop with Purvis/Stevens on *Health Care Management*.

IDS Site Manager Wittenberg in coordination with AID Manager Nicole Simmons recommended follow-on assistance to the *Financial Management Workshop* at three (3) IDS facilities in order to:

- Facilitate and train for the successful implementation and the obtaining of tangible value from these basic financial tools and techniques;
- Begin the initial automation process of some of these financial management methods;
- Document, in the form of a “How-To Manual”, the methods and steps taken during the automation process (by these three sites) to promote a more rapid dissemination of such efforts and accelerate the learning curve of other facilities.

1.2 Objectives of Field Work

The primary objective of the consultant was to provide on the job training to designated counterparts in three facilities to strengthen the financial management capabilities. This activity was completed in two phases, with Phase One working with counterpart institutions to establish basic budgeting, financial performance, and cost accounting models. Phase Two was directed at the refinement of the information systems (and software development if necessary) and more advanced training on the use of budgeting, performance management, and cost accounting information in management decisions.

These objectives remained intact. It became apparent there was a need to start the “automation” function earlier in this project than previously thought. This was done for a number of reasons including:

¹ *Management Accounting and Control: A Manual for Health Care Organizations* Task 053, Else & Wouters, April, 1996.

- Finding some synergy including complementary motivation in automating the financial assistance being offered as it is provided - “helping counterparts to learn automation as we apply financial principles”,
- Recognition of the long learning curve needed to incorporate automation, and thus taking advantage of the longer nature of this particular technical assistance,
- The lead time for creating and implementing any “software” design that would accommodate language and other technical production aspects,
- The timing of the delivery of selected computer equipment with the availability of the technical advisor.

Thus, the automation effort and the resultant creation of the “How-To” manual documenting the steps for designing and implementing such financial information systems as well as the recommended methods for analyzing/using the information in a generic fashion began in Phase I.

1.3 Field Activity

The field work advanced the use and application of previously taught financial management skills and techniques, identifying particular tools and techniques that can best provide pragmatic and immediate value to each respective facility or organization, and facilitating their use and potential automation. Specifically, the field work was focused on the areas noted below with a check☑.

Activities and Deliverables Task #324	Odessa Clinical	Kodyma Hospital	Hosp #10	Odessa Oblast	Munic ipal	FHC	SFC	Belivka	Other
Budgeting	☑	☑	☑	☑	☑				☑
Cost Accounting	☑	☑	☑			☑	☑		☑
Performance Mgt.	☑	☑	☑	☑					☑
Computer Training	☑	☑	☑	☑	☑			☑	☑
Final Presentation	☑	☑	☑	☑	☑				☑
How To Manual (Inf. Sys.)									☑

The 3 target IDS hospitals were found to be increasingly in the survival mode with all failing to meet payrolls, unable to purchase necessary medications, and accruing expenses at a rate in significant excess to cash flow. The economic situation observed during the field work has worsened since the winter months. In Kodyma, there are few medications being purchased or provided except for severe cases. Occupancy has fallen, salaries have been withheld. There is a similar situation in Municipal Hospital #10 where 4 months of salaries have been accrued, but not paid. The Odessa Oblast Hospital is no better off with four months of accrued salary payments on the books. Porridge instead of meat at the Oblast Clinical Hospital is now being provided to inpatients requiring food. Other institutions have severely modified/stopped selected inpatient food services relying on family support to fill nutritional needs. Other startling descriptions of a growing constraint of resources in health care facilities are frequently shared with the ZRP staff.

The implications of the economic situation on the current technical assistance was significant. In the case of Kodyma, for example, the economic situation was so bleak that the value of producing departmental costs was very low in that calculated costs did not reflect resource requirements or efficiency². Thus, the technical assistance provided concentrated on implementing financial tools that best met these fundamental and emerging realities. Specifically, assisting these organizations to manage resources during periods of severe resource constraint. The focus of this assistance centered around three subject areas:

- Decentralized Budgeting,
- Cost Accounting where appropriate, and
- Performance Management.

The following summarizes the application of these subject areas at each of the field sites.

Odessa Oblast Hospital - Because of dwindling funding, senior management wanted to begin an initiative for making more rational decisions based on objective data in allocating limited funds, optimizing department performance, and monitoring key operational indicators at the facility and departmental level. This included establishing a capability to decentralize the global facility budget, producing departmental service costs, and establishing basic performance indicator system based on this information.

The decentralization of the global budget occurred over 56 departments based on 5 months of current year-to-date information. The decentralization was accomplished with the application of a variety of cost accounting allocation measures implemented by the Hospital with the assistance of ZRP field work. After the initial decentralization of the global budget, those departments deemed to be overhead were re-allocated to the direct and ancillary departments. The overhead methodology was a 3-step multiple overhead allocation process of which 14 departments were involved. After refining the process of decentralization, the entire effort now takes about a half a day and soon a matter of hours to accomplish. The process used to take 30 to 45 days to decentralize a budget without overhead allocations. The above activities were also automated in an easy to use computer system designed, developed, and implemented during the field work.

Reasonableness tests of the decentralized budget were also accomplished. In addition, the counterpart management requested selected departments be withdrawn from the budget while others be further broken-down (the central laboratory). Various scenarios of a decentralized budget can now be compared to other scenarios. Senior management is thrilled.

Service costs in selected departments within the Odessa Clinical Hospital were also identified. The departments include Surgery, the Admissions/Emergency Department

² In cost accounting terms, the costs were outside of the “relevant range”. This means, in part, there was little correlation to changes in the behavior of costs as volumes changed. Because costs have been reduced so severely, the definition of service-level costs hold marginal meaning to decision-makers where resources are so small, they do not reflect the minimal amount of resource required to deliver a service.

and the Bio-Chemistry Laboratory. Because the Bio-Chemistry Lab was one of the more complex targets of cost accounting, it was chosen as a worthy target for costing and training counterparts. Advanced methodologies of cost accounting were incorporated in this department. Specifically, the cost objects were defined as six groups of tests based on staff time, with each group containing 3 categories based on varying processes. (18 cost objects in total). With the assistance of the department manager, actual volumes for the 5 month period were calculated and costs identified. Direct departmental participation occurred throughout the field work. All budget and cost calculation methods were an outgrowth of the Financial Management Seminar.

Finally, the above departmental expense and service cost information was then linked to key operational statistics to provide essential performance management/indicator capabilities. The capability allows a manager to compare nearly any statistic from month to month in relation to departmental costs. Comparisons made from month to month can spot cost trends and abnormal cost behavior. Finally, the manager can set “minimum and maximum” parameters of acceptable unit cost behavior and report adverse variances without having to sift through all of the costing data. This, in fact, was a “management by exception” approach.

Additional training on the relevant subjects and systems also occurred at the Odessa Clinical Hospital. Some computer training is still being provided through the Odessa ZRP Office. In addition to budgeting and cost accounting, the following subjects were discussed. Training material outlines are shown in the Annex.

- *The Development of a Performance Management Model*
- *Benchmarking for Performance Management*
- *Framework for Designing and Implementing Financial Information Systems*
- *Four Methods for Prioritizing Decisions*

It should be noted the field work at the Oblast Clinical Hospital can be described as extremely constructive and useful. Key to this was the work environment, the commitment of senior management to find new ways to manage, and the ongoing and sincere interest of participants to improve how health care services are managed on a day to day basis. While many challenges existed, such as the availability of key managers, there was always a willing and successful effort to resolve problems as they arose.

Kodyma Hospital - Kodyma continues to experience great difficulty in finding a means to fiscally survive during continued budget cuts and its position as a “lower-priority” rural health facility. Complicating the macro-economic situation is a micro-economic operating reality: The facility is under-utilized and overstaffed. The Head Doctor expressed a desire to re-organize the delivery of all of the Kodyma health care services which would result in a better alignment of resources with patient needs. The reorganization sought to consolidate within the main hospital various satellite clinics that are under-utilized and over staffed while removing a number of mid-level administrative management through an internal reorganization. As one example, the Head Doctor is proposing to reduce his current nine “deputies” to a total of three.

The re-organization is eventually targeted to cut about 300 positions and 300 beds while maintaining the ability to meet patient demand within his budget. The process has begun with the cautious approval by the Rayon and Oblast Authorities.³ ZRP field work has focused on strengthening the financial management capabilities in this regard by identifying and training the local staff on how to identify and maintain such financial information to facilitate the above analysis and accomplish such meaningful reform. This was done by applying decentralized budget techniques, providing basic computer skills and capabilities such as spreadsheet analysis, and the creation of a performance management model that facilitated the identification of staffing levels that support various budget scenarios. The global budget has been decentralized to 30 departments. This decentralized budget which includes the satellite clinics, now provides an ongoing basis for analyzing the financial effect of various staffing and organizational scenarios both before and after a hospital re-organization.

During the field work, two financial management personnel from Kodyma traveled to Odessa and received extensive training on computer systems. The training course was used as a Case Study in the “How-To” Manual titled, *‘Designing & Implementing Financial Information Systems with Recommended Methods for Analyzing/Using Information for Management Decision Making’*.

Municipal Hospital #10 - It was initially intended to work in both the hospital and the polyclinic. However, it became apparent the hospital personnel were not prepared to promptly deliver the necessary information to make the field work viable. In addition, an ongoing counterpart to work with on a regular fashion was not quickly established on the hospital side. As a result, the work focused on the polyclinic where departmental service costs were requested to be identified and data was available.

The polyclinic is a busy municipal clinic which provides a stream of user fees to the facility.⁴ The primary purpose of the cost data was for pricing and basic cost performance management. In order to produce such financial information, the global budget of the entire facility needed to be split into hospital and polyclinic costs, and the polyclinic costs needed to be decentralized among the seven major departments. Because financial information was not forthcoming, this process took about 4 weeks. Normally, the process should have taken one week. Eventually, the fieldwork decentralized the budget according to 5 months (January to May -1996) of actual data. Costs for all seven polyclinic departments were then determined with the key physician(s) defining the relative value units.(RVUs)

³ The Authorities have allowed staff reductions and bed closures. Some of these cuts are only seasonal in nature reflecting the ebb and flow of patients over the course of a year. On the other hand, the fact that staffing levels have been adjusted according to volume fluctuations represents a major step in adjusting resources to actual needs. This promotes costs to behave as variable, as opposed to fixed, and thus is a more efficient and effective use of limited resources considering the over supply of staff and the under utilization of beds.

⁴The diagnosis department contributes about 400,000,000 Kps a year to the financing of the facility but it is felt can do much more.

Of particular interest to the Polyclinic was the methodology for costing that was employed. The method⁵ allowed for the individual service costs to reconcile to the total expenses of the Polyclinic. Costing efforts created from the bottom-up⁶ had never been capable of reconciliation while the RVU allocation method is nearly “self-reconciling.” Because the legal environment often dictates the formula for pricing, the ability to consistently reconcile costs helps managers avoid legal challenges as to the accuracy of the costs.⁷

Additionally, Polyclinic Management liked the ability of the costs to be determined quickly and adjusted with relative ease. Due to the changing economic environment and the resulting need to rapidly adjust the mix of services offered depending on available funds, the costing system needed to be capable of reflecting frequent changes in operations. Previous methods that attempted detailed costing analysis were never capable of being maintained or updated with ease.

A performance management model for the Polyclinic was provided to the Polyclinic’s chief doctor.⁸ A suitable counterpart to train on the systems and methods was eventually found during Phase II and she is progressing in her ability to maintain and continue the field work to date. Follow-up in this area will be required. (See recommendations) Finally, cost determination for additional hospital departments is scheduled to get underway in the fall according to the Head Doctor.

The field work in this facility identified important challenges when attempting to enhance the financial management of an institution. These are lessons for those who desire to efficiently enhance financial management capabilities within a health care facility and include the need for:

- Ongoing and continual support from the top management: e.g. a mandate to change
- Properly trained economic and financial managers who understand the principals and concepts of what is trying to be achieved. Short of this, time to train these managers.
- An accurate source of information that is readily available.
- A sense of priority and urgency in the effort to change
- The identification of a team responsible and a defined timeframe for implementing recommended changes.

Family Health Center - The decentralized budget and cost accounting software was placed on the computer system of the FHC. An overview and detailed demonstration of the current field work at the above three facilities occurred using FHC data with the Head Doctor and Chief Economist in attendance. Both expressed great value in the

⁵The method was RVU costing as defined in numerous Trip and Technical reports by Else and Wouters.

⁶ A bottom-up cost model is created when the cost analyst first identifies the component costs and the sum of these component costs should equal the total costs of the department or facility. RVU costing is a top-down approach, where the analyst starts with an understanding of the total costs and assigns these costs to cost objects.

⁷This was a particular concern of the Family Health Center and the Self-Financing Clinic, as well.

⁸The model was the same as originally defined by the Head Doctor of the Oblast Clinical Hospital.

information in reducing labor time in providing analysis, improve the quality/maintainability of the costs, and maximize profitability for paid services. It is not known, however, whether the information will be maintained by the FHC. Data collection forms were handed out to FHC management with an offer to assist them in costing all of their departments. However, follow-up on the data collection process occurred on three occasions, and, to date, the data has not been provided. There could be a number of reasons for this delay. August staff vacations were clearly a part of the delay. The potential for the costs to be “published” might also be an issue.⁹

Self Financing Clinic - A roll-out of the cost accounting methodology occurred within this facility of the current field work to date at the above four facilities. The Clinic is limited by old technology hardware, but was very interested in the process. To meet this need, ZRP staff produced a spreadsheet version of the cost accounting model for the facility and provided site training on automating cost accounting techniques using an older version of Microsoft Excel. This met the needs of the Self-Financing Clinic and they were quite pleased with the labor saving characteristics of the program. All had attended the Financial Management Seminar in February and so the training was greatly expedited.¹⁰

Oblast Level - Health Administrator - A roll-out of the decentralized budget and cost accounting tools took place at the Oblast Administration and resulted in providing the counterparts with their first ability to automate the task of allocating resources among facilities. Of specific interest, was the new-found ability to run various scenarios through a computer so as to enhance decision-making regarding how and to whom resources should or can be allocated.¹¹ In practice, it seems, any new method to allocate resources will need to be compared to older methods. Likewise, even the most sophisticated of resource allocation methods will likely be “adjusted” based on other decision-making criteria such as political pressure, social mandates, or other non-financial information.

Also, of particular interest on the part of the Administrator was the ability to establish a more meaningful performance indicator system among member hospitals. The Administrator was clearly interested in doing this work and aligning the performance management system at the Oblast level with a hospital based performance management. (See recommendations)

Municipal Level - City Health Administrator: A roll-out of the decentralized budget and cost accounting tools took place at the Municipal Administration and resulted in providing the counterparts with their first ability to automate the task of allocating

⁹ It should be noted, however, the FHC is in a position to obtain great value from such an effort. The cost data would optimize their profit margins and materially contribute to their financial health. Should the financial where with all to survive ever be threatened at the FHC, this type of effort would materially improve their situation.

¹⁰ The Self-Financing Clinic has received a number of inquiries from public facilities asking their cooperation in setting up “fee for-service” programs. The severe constraint of resources seems to be placing sufficient pressure on public facility managers to find alternative funding sources no matter how Article 49 of the Constitution is interpreted.

¹¹ 19 Hospitals were modeled under a variety of allocation scenarios. Training occurred with selected members of the Oblast Administration including their Economist and Administration advisor.

resources among facilities. 65 Hospitals were modeled under a variety of allocation scenarios. The tools and techniques were reviewed and shared with the Municipal Decision Support specialist, Mr. Dyachenko who is also a member of the National Academy of Sciences and is charged with helping to design a country-wide health care computer system. The interest by the Municipality was centered more on the automation process than the underlying financial management processes. Because none of these individuals had attended the Financial Management Seminar, progress was slowed.

2.0 Recommendations

Recommendations have been separated into three categories: *General*, *Subject Specific*, and *Facility Specific*.

2.1 General Recommendations

1. Try, when possible, to link financial reforms with a parallel effort to computerize the process. Computerization and improved financial management go together. Trying to enhance financial management in a manual environment is like swimming with one hand tied behind your back. While the assistance provided in this field work can, and at times, was done manually, there are limits to the velocity of financial reform given manual accounting and decision-support methods. Historically, the greatest enhancements to the efficiency of financial management have been made with the automation of transaction based systems coupled with the automation of selected decision based systems. This should be recognized and addressed, where possible, in field work. For those facilities that are still in a “manual” mode, the methods presented and taught during this field work still apply. For those facilities that are interested and committed to automation, the methods will hold even greater benefit.

2. Increase the technical assistance targeted at strengthening the financial, operational, and clinical management of the health care delivery system at the Oblast Level. Oblast administration offices are major influencers in many of the day to day “purse, policy, and quality of care” strings of the health care delivery system at regional levels. Administrators are having to make very difficult resource allocation decisions during a period of severe resource constraints while balancing those decisions with clinical and operational results. These decisions are being made without the assistance of readily available and objective financial, operational, or clinical outcome data.¹² This is causing inefficiency in how scarce resources are being employed at a time when resource allocation decisions need to be at their absolute best.

To help in this regard, it is proposed a basic computer capability be rapidly implemented for improving the analytical capabilities of these offices. This would include the creation of a *basic resource allocation and performance indicator*

¹²Administrators at the regional level are often relying on 1970 USSR defined norms and marginal computer capabilities which do not readily address the current economic or clinical technological environment.

system. The *resource allocation* (part of such a) system should be one of making resource allocations based on a variety of objective criteria under a variety of scenarios.¹³ The accountability measurement (part of such a) system should link resource allocations to essential operational, financial, and most important, (eventually) to clinical indicators. In this way, regional administrators will eventually advance the efficiency and effectiveness of limited resources under their control. Benchmarks for success of such technical assistance could be measured by:

- An increase in the intensity of available resources applied per occupied bed.
- An increase in the intensity of available resource applied per visit.
- The collection and measurement/monitoring of key operational, financial, and clinical performance indicators at the regional level to a degree sufficient to cause a change in how resource allocations are made.

The economic situation would suggest the need for such a model to demonstrate how this process could be achieved in a more rational and rapid manner. In part, this recommendation is targeted at the implementation process of pending per-capita financing proposals and seeks to expedite the analysis and evaluation of new allocation methods on the part of Oblast level health authorities. Providing these authorities with more tangible assistance regarding how they can better distribute, monitor, and measure the value of their resource allocation decisions would be value adding and quite timely. The situation is so critical, mistakes regarding resource allocations are costly to the patient population. *It would seem risky to propose a new method of allocating funds without a system in place to measure and monitor ongoing performance in a timely manner.*

The Odessa Oblast Administration office was most interested in this type of assistance. This field work had the opportunity work directly with the authorities in this regard and found particular interest in reforming/enhancing/expediting this decision-making process. There are also a number of program advantages to providing direct technical assistance to the Oblast Administration including:

- Demonstrating reforms within the Oblast Administration holds a greater opportunity to impact a member hospital;
- Leveraging the training of a small group of people within the Oblast Administration across an entire region;
- Leveraging the use of one computer and the required training and support across a number of hospitals;
- Aligning the technical assistance dedicated to the reform process with the known policy processes;

¹³ For example, once an Economist defines a new “per-capita” method of allocation, the model can be quickly entered into an automated allocation environment that can readily compare old methods versus new ones. It is not unusual to expect managers such as an Oblast Administrator, to want to see multiple iterations of alternative allocation methods under changing assumptions. Equally, it is not unusual to expect such decision-makers to modify proposed methods defined by rational economists due to social or political reasons. If this is left to be done in a manual fashion, even the best methods of allocating funds will be slow in implementation diminishing their immediate value to patients.

- Demonstrating the value of the technical assistance to the highest levels of decision makers regarding health care delivery. This greatly expedited and focused the attention of Head Doctors who reported to the Administrator.

In order accomplish this recommendation, it is necessary to have an excellent working relationship with the respective offices. The field work during this task enjoyed just such a relationship with the Odessa Oblast Health Care Administration.

3. Lessen the amount of new direct financial technical assistance to IDS sites.

There is a diminishing return on the quantity and pace at which single IDS sites can incorporate change or new methods. It takes time for organizations to change and incorporate change in a meaningful manner. Therefore it is recommended to only maintain the scope of current financial management technical assistance with the most successful IDS sites, (Oblast Clinical Hospital and Kodyma) to avoid increasing the scope of assistance, and concentrate on continuing to assist these organizations at becoming excellent in using and applying and improving their many new tools and techniques for financial management.

There is also a diminishing return on how influential a few sites can be at convincing others to aggressively apply these new found skills and techniques. While the assistance to date proved useful and value adding to all organizations, the ability to leverage this experience to other institutions seems limited in form and duration unless the Oblast, Rayon, and Municipal policy makers are equally willing to expedite such efforts through the health care system. Thus, it is recommended that continuing technical assistance at the hospital level complemented with a complete and coordinated effort with Oblast, Rayon, or Municipal authorities. Such technical assistance agenda's might include:

- The definition and costing of a "basic" set of health care services. While this might appear to be outside of the scope of current financial management assistance, it is not. The technical assistance provided in cost accounting can be applied to cost such a "basic" definition of services. Given the new Constitution and the nebulous understanding of Article 49, it is only a matter of time before the need arises to define the macro and micro costs of a "basic" set of free health care services.¹⁴
- The common definition and implementation of a hospital wide performance management model. The old models are often based on 1970 USSR agendas, guidelines, and attitudes. Specifically, it is recommended the Odessa Oblast Clinical Hospital act as a demonstration site for the Oblast Health Administration's effort to redefine how hospital performance management should be monitored, measured, and evaluated.

¹⁴ Even in countries that have some of the most comprehensive plans of "free care" (such as Holland) there is a defined set of basic services that are "free" and a definition of services that are not free. Sooner or later, hospitals will need to separate the costs that are employed for free care from those services that are not free. Modeling how this would be done in concert with a program to define a basic set of services would be useful technical assistance that combines a many aspects of the ZdravReform effort.

- The implementation of an automated system of collecting and reporting key operational and clinical statistics. It is recommended Kodyma and the Oblast Clinical hospital in concert with the Oblast Health Care Administration act as a platform for such assistance. (See Item 3 below)

4. Establish a micro-computer based data collection and decision support tool that will link regional authorities (Oblast Administration) with hospital sites. There is a material need to collect accurate data among health care providers regarding the incidence, treatment, and, outcomes of health services. Linking this information to essential financial and operational data is essential for the ongoing management of the population's health. This cannot be accomplished efficiently and maintained with relative ease with current manual systems. Rather, the process should and can be easily automated. The specific purposes of such a system (as well as the benchmarks for measuring success) would be to:

- *Better Identify problems.* The objective is to seek the right solutions to the right problems rather than the right solutions for the wrong problems.
- *Provide for measures of costs and benefits.* The objective is to provide for a financial cost analysis as well as a scheme for evaluation of clinical efficiency and effectiveness (e.g. benefits).
- *Promote the identification of alternatives* The objective is to offer alternative ways of achieving the decision-makers objective(s). This would include the specifying of a range of alternatives compared to the current situation.
- *Provide for an evaluation framework of those alternatives.* The objective is to support an understanding of the predictive consequences of an alternative decision and compare those alternatives.
- *Better monitor and evaluate results.* The objective is to monitor and assess the impact of the decision

Such a system could easily be created locally by counterparts with technical assistance in a period of a few months. The computer system does not have to have "on-line" communication links. Rather, it would be an integrated tool built with off-the-shelf software tools as demonstrated under this task. It is recommended such a system be created at the Odessa Oblast health Administration and linked to the Odessa Clinical Hospital.

5. Improve the process for obtaining and delivering computers to IDS sites. Strengthening the financial management among IDS sites is facilitated with the use of computers. Considering most financial management processes are manually maintained, a material operational, financial, and management improvement can quickly be made through automation. The duration of time it takes to get a computer once approved seems too long. Given the time it takes to incorporate computer technology into management processes, to wait until the end of the program to deliver the computer is not seen as the correct way to go about this.

2.2 Subject Recommendations

Budgeting Recommendations

1. Continue to encourage the breaking down of global facility budgets to sub-units within an organization as this is a fundamental and necessary step for performance improvement. This will produce the necessary data to more objectively account for the efficiency and effectiveness of health care delivery at the department level. Budget decentralization can occur through manual systems but the process is greatly enhanced through basic automation.

2. Continue to refine and improve the methods for automating the breakdown of the budgets to enhance their accuracy and increase the possibility for iterative looks at alternative resource allocation scenarios. This will enhance the quality and velocity of decision-making regarding how resources are allocated and provide a more objective evaluation and analysis as to why some of the older methods of resource allocations are not rational given the current state of financial affairs.

3. Continue to identify and automate where possible, particularly at the Municipal and Oblast level of authority, the ability to compare how resources are being employed among the facilities. (e.g. the establishment of a performance management model at the Oblast and Municipal level, not just the IDS level) A systematic comparison and measurement of key processes, products, or services against those of other facilities will greatly facilitate improvements in the decision-making process regarding how resources should be allocated. Such comparisons should be a systematic and perpetual measurement of key processes and services being provide among facilities.

4. Help to automate all of the above budgeting functions as soon as possible.

Because of the lack of computer technology and the need for extensive computer training in order to bring users to a reasonable degree of efficiency, it is also recommended centralized computer decision support centers be created at the Oblast and Municipal levels. Such centers could more easily be trained to collect, analyze and report key data to the facilities. This would immediately improve the evaluation and performance management of larger blocks of health care resources and avoid lengthy and costly equipment/software purchases. In the final analysis, an IDS site is just one site and the imminent need to improve how resources are being allocated and accounted for across an entire population seems a higher priority.

Cost Accounting Recommendations

1. Do not employ advanced cost accounting techniques at those institutions where resources have been so severely cut the value of the information is limited.

The severe resource constraints of some hospitals are making the value of detailed cost accounting information at the service level of marginal value. Because costs have been cut so severely, the resulting service level costs that are defined are no longer in the relevant range of accuracy or decision-making value at some institutions. This was found to be the case in Kodyma . In some institutions, however, the cost accounting data at the service level is still useful. This was the case at the Odessa Clinical Hospital and the Municipal Hospital #10, as well as the Family Health Center and the Self-Financing Clinic.

2. Continue to simplify and automate the cost accounting process It is strongly urged to avoid micro-costing or other such complex methodologies given the poor levels of computerization and the relative cost of costing. Cost accounting information is costly to produce and the process must be streamlined even further. This can occur through the refinement of the off-the-shelf computer systems to further facilitate the process and offering targeted computer training. The production of cost accounting data where computerization is not available should be carefully evaluated in terms of its necessity. While costs can and have been determined through manual systems, the ability to maintain the information is a major area of concern. Specifically it is recommended that cost accounting be manually produced only when:

- Costs have a very specific and immediate purpose such as setting prices.
- An RVU or equivalent allocation methodology is employed
- Costs can be calculated by one person
- Costs will not have to re-calculated each month. (This generally implies a more stable economic situation.)

3. Continue to automate the cost accounting processes and create a center of excellence in this regard to promote the ongoing production, use, and analysis cost information. This center of excellence might best be served to be located within the Oblast and Municipal governing authorities, as well as in a University setting. The field of health care cost accounting is large one. The need for such services will be an ongoing requirement. The Financial Management Seminars have proven very useful. Thus, it might be equally useful to incorporate such an effort in the educational process of the Ukraine.

2.3 Facility Recommendations and Specific Facility Follow-up

Oblast Clinical Hospital

1. *Follow-up to insure continued computer training is occurring.* The young analyst (Sasha) is excellent with the computer and seems quite capable of operating the budgeting, costing, and performance indicator system. However, the Head Doctor would like to expand the number and variety of system users capable of maintaining the budgeting and cost accounting data. Sasha has been designated the “in-house” teacher. He could probably use some assistance in the provision and delivery of a more formal training agenda such as the one specified in the “How-To” manual. A good target of training would be the statistics personnel as they will need to enter statistical data into the system on a monthly basis.
2. *Encourage them to continue manipulate the decentralization software* - encourage them to work with the system revising their decentralized budgets so they are more and more reasonable. This means they may want to continue to hone the allocation measures, including the overhead allocation sequence, or methods.
3. *Make sure they are entering and maintaining performance indicator statistics.* These provide operational indicators and reveal trends which the Head Doctor is interested in observing on a monthly basis.
4. *Get them to cost the Maternity and Gynecological service area.* They are a site for the new US AID “reproductive health” project. The identification of service level costs will be useful in their analysis of the cost impact of clinical reforms I these departments.
5. *Document any changes in resource allocation that have occurred based on the technical assistance recently provided.* The objective here is to make sure they receive ongoing benefit/value from the work. Measurable criteria, in this regard, will be found in changes to their “old” method of allocating and managing resources. This would include decisions related to the closing of beds, changes in staffing levels, the identification and use of new performance indicators, and/or new attitudes as to the levels of accountability at the department level.

Get the Head doctor to share the work that his facility has done with others. An overview presentation was prepared with his cooperation and it would be useful he had the opportunity to share this effort with other hospitals.

Kodyma Hospital

1. *Continue the emphasis on building computer skills to accomplish normal accounting and financial functions.* These skills will greatly enhance their productivity and data accuracy. Similar to the Oblast Clinical Hospital, encourage this training to go beyond the two individuals already trained. They need to be making basic spreadsheets that can add, subtract, multiply, divide, show percentages, and “Paste -Link” from one worksheet to another. I suggest they make spreadsheets of something that will help them in their mundane daily work. (e.g., immediate value)
2. *Establish a link between the Kodyma Hospital with the Oblast Hospital* to get the Oblast Hospital to share any and all Excel files they use in the normal accounting process with Kodyma.
3. *Encourage the users to continue to decentralize the their budgets.* Training stills needs to be provided in this regard as it seems to take some time to get them to internalize the processes and functions involved. In part this is because none of them attended the Financial Management Training seminars this past winter. As a suggestion, bring Sasha from the Oblast Clinical Hospital up to Kodyma and have him train the staff. This would save time, internalize he information within Sasha, and support our imperative to have the counterparts taking greater responsibility for their own health care system. Follow-up and insure they are working with the system revising their decentralized budgets so they are more and more reasonable. This means they may want to continue to hone the allocation measures, including the overhead allocation sequence, or methods.
4. *Get the Head doctor to share the work that his facility has done with others.* An overview presentation was prepared with his cooperation and it would be useful he had the opportunity to share this effort with other rural hospitals.
5. *Follow up on training course scheduled for September 13th in Odessa at the ZRP office.* A training course with all of the IDS users is scheduled for September 13th. The Kodyma economist will come to Odessa one day early for additional training. It is suggested the programmer be made available during this period to answer any questions or respond to any problems.

Municipal Hospital #10

1. *Continue to train the main user/analyst, Oksana.* This user was identified only in the last part of the field work and so it will be necessary to continue her training. Like some of the others, she did not attend the Financial Management Seminar and so is in the dark, somewhat, about the techniques employed in this regard.
2. *See if the Polyclinic will actually use any of the data before a computer system is installed.* Until then, provide for ready access to a computer system in the ZRP office. Examples of “use” would be the establishment of prices based on the costs, a need to re-decentralize budgets based on new cuts in the municipal funding levels, or any interest in monitoring performance indicators within the facility or in concert with the Municipal Health Administrator.
3. *Encourage Oksana to share the budgeting and costing processes with Koval.* Koval represent the hospital side of the equation and it would be useful, although somewhat slow to get Koval on the system. If this sharing of information is not forthcoming, it is indicative of how they intend (or do not intend) to use the new information resources.

3.0 Information Systems: Field Activity Overview

A local programmer used by the Odessa ZRP office was hired to develop a very basic software tool which aided in the decentralizing of budgets and the production of cost accounting data. The software was designed with standard “off-the-shelf” tools (Microsoft AccessTM and ExcelTM), and was built in the host language. The tool was created over a period of a few weeks. The value of such a tool was multi-fold including:

- Expediting the breakdown of the budgets
- Improving the accuracy of the calculations
- Allowing for iterative attempts under changing assumptions
- Providing for ongoing budget breakdowns as significant changes in funded amounts occur
- Calculating product and service costs under different global budget scenarios
- Linking volume indicators with departmental and service level costs

The “program” is very straight forward, intended to be easily modified by the user as they desire to customize the application to their specific needs, and capable of being used as a facilitating tool to show “how-to” automate selected financial functions that will have a high return on the users time and resource investment. The program has been operating smoothly and includes a multiple step-down departmental overhead allocation capability, an ability to link outcome statistics with operational costs, and an ability to report this information.

4.0 The “How-To” Manual - Overview

Per the Task Order, a “How-To” manual was written titled “*Designing and Implementing Financial Management Information Systems*”. The manual is intended to accomplish two principal purposes. First, to communicate how a few selected hospitals designed and implemented selected financial information systems. Sharing these experiences and outlining the steps and processes documented through their effort is seen as a valuable method for accelerating the learning curve of others involved in similar efforts.

Second, to communicate sample methods and roles for analyzing and using this information for management decision making within a Ukrainian health care institution. The manual takes the approach that it is of marginal value to automate a financial management process or activity unless there is some tangible benefit or purpose to the automation. As such, the manual offers selected outlines of what the automation effort was directed to accomplish and how, once automated, the information was/is being used to facilitate the management of key financial concerns.

It should be noted, the automation effort in some of these facilities was the very first time a micro-computer had been employed as a financial management tool. As a result, there was a significant learning curve not only in understanding the automation processes involved with financial systems, but of the basic principles of operating a computer itself.

The Table of Contents of the manual including the first chapter (Section 1: Scope) is attached as Annex I to this document.

ANNEX I

Designing and Implementing Financial Management Information Systems

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I. Scope of Manual

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- B. Intended Audience
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II. Objectives of Designing and Implementing Financial Management Information Systems

- A. Objectives
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V. The Design and Implementation Process of Financial Information Systems

- A. Identification and prioritization of key financial strategic issues in need of automation
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Appendix

- Case Study #1 - *Aligning Strategic Priorities with the Design of an Automation Effort for Producing a Departmental Performance Management System*
- Case Study #2 - *Implementing a Financial Management Information*
- Case Study #3 - *System Training: A Course Agenda*

ANNEX I- *Continued*

I. Scope of Manual

A. Purpose

This manual is intended to accomplish two purposes. First, to communicate how hospitals go about the design and implementation of financial information systems. Sharing experiences and outlining the steps and processes documented through their effort is seen as a valuable method for accelerating the learning curve of others involved in similar efforts.

Second, to communicate the applications and roles for analyzing and using this information for management decision making within a Ukrainian health care institution. This manual takes the approach that it is of marginal value to automate a financial management process or activity unless there is material benefit to the organization. As such, the manual offers examples of automation efforts and, once automated, how the information is used to facilitate the management of key financial concerns.

B. Intended Audience

The concepts and steps provided are meant to apply to:

- Key hospital and polyclinic managers
- Economists
- Accountants
- Information system specialists and system planners
- Software developers
- Hardware and software suppliers
- Management consultants
- Other interested parties of the Ukraine.

This manual will help these readers:

- Begin to understand the relationship between the cost and value of collecting and automating underlying transaction systems with the automation of higher level management processes. The manual promotes an understanding of how these two issues are intertwined.
- Make improved decisions regarding where, when, and how to initiate, and implement inaugural computerization efforts within their institution given minimum experience and expertise with computer tools and technology.
- Understand the essential steps involved and approximate time commitments to accomplish various levels of automation.

ANNEX I- *Continued*

- Define the roles and responsibilities of various key players in the automation process.
- Define and encourage the establishment of selected benchmarks of success for monitoring the progress of an automation effort in the finance area.

C. Methodology

The methodology of this manual is rooted in five documentative activities including:

1. Making the steps clear to others
2. Focusing on key processes & principles
3. Demonstrating through example pragmatic approaches that proved successful
4. Identifying common pitfalls and rules of thumb
5. Sharing progress to date with other facilities

Finally, this manual is not a programmers guide to the development or selection of software and hardware. All of the software used in this manual was obtained “off-the shelf” allowing each facility maximum flexibility to build/design/adopt the software to fit their unique needs and yet remain flexible as needs and expertise within an institution develops over time. The skills and techniques provided in this manual require marginal computer skills that can be learned through relatively short periods of training and hands-on experimentation.

ANNEX II

LIST OF DOCUMENTS CONSULTED

“Internal Control and Cash Management”, Bradford Else, *ZdravReform* Program, November 1995.

“Institutionalizing Improved Cost Management and Internal Control Systems in Polyclinic #2”, Bradford Else, *ZdravReform* Program, November, 1995.

L’viv IDS Implementing User Fees and decentralized Management Accounting Systems in City Hospital No. 1: A Tool Kit, Wouters, November 1995.

“Generally Accepted Auditing Standards”, AICPA, 1995.

“Internal Control and Financial Statement Audits”, AICPA, 1991.

“Trip Report- Second Technical Assistance to Skole Rayon”, Cowley & Makinen, February, 1996.

“Management Accounting and Control: A Manual for Health Care Organizations”, Task 053, Else & Wouters, April, 1996.

“Critical Evaluation: Self-financing at the Family Health Center in Odessa, Ukraine” Task Order 024, Raney & Makinen, August 1995.

“Financial Reporting and Cost Control for Health Care Entities”, Prince, AUPHA Press, 1995.

“Improving Efficiency, Quality and Access under Global Budgeting at City Hospital #1 in Lviv”, Wouters, Wouters August 1995.

“Lviv IDS Implementing User Fees and Decentralized Management Accounting in City Hospital #1: A Tool Kit”, Wouters, November 1995.

“Roll-out of Financial Management Tools and User Fee in Zhovkva Rayon”, Trip Report, Wouters, March 1996.

ANNEX III

Training material:

(English & Russian Versions Available)

The Development of a Performance Management Model
Benchmarking for Performance Management
Framework for Designing and Implementing Financial Information Systems
Four Methods for Prioritizing Decisions

Filenames:

324bech.doc

324perf.doc

324pmgt.doc

324sys.doc

Annex IV

Summary Worksheet of Strategic Priorities of one IDS site

Insert Filename 324prior.xls

ANNEX V

PERSONS CONTACTED

ZdravReform/Odessa

Tom Wittenberg, IDS Advisor
Jennifer Lissfelt., IDS Dissemination
Sergey Kolesnik, Interpreter/Translator
Irina Zabolotnaya Interpreter/Translator
Sergey Artarov, ZRP NIS West Information Dissemination Assistant
Olga Tereshchenko, IDS Office Manager
Roman Kozogladuk, ZRP Driver
Yuliya Medyuk, Secretary IDS Odessa
Yevgeniya Timashova, New Secretary IDS Odessa

Odessa

Genrick Rouvinskiy, Information Systems & Software Development

Municipal Hospital #10:

Dr. Veniamin Chernetsky - Head Doctor
Dr. Anatoliy Anchev - 1st Deputy - Chief of Inpatients
Dr. Grigoriy Astvatsartryan - Head of Polyclinics
Mr. Koval - Chief Economist
Oksana Voytenko - Computer/Systems operator

Oblast Hospital :

Dr. Vasiliy. Gogulenko - Head Doctor
Dr. Bozhenko - Head of Polyclinics
Mrs. Liudmila Trushkina - Chief Economist
Mrs. Olga Sknarina - Chief Accountant
Dr. (Mr.) Melnick - Chief Doctor Surgery
Mrs. Kalyuzhnaya - Head of Statistics Department
Dr. (Ms.) Posohova - Dep. Chief of Gynecology
Dr. (Ms.)Svetlana Streltsova - Chief Doctor Inpatients

Kodyma:

Dr. Vitaliy Borscht - Head Doctor
Mr. Petr Yakovlevich Melnik - Member of the National Assembly- Kodyma Region
Mr. Ivan Illarionovich Trostyanetsky - Administrator, Kodyma Rayon
My Ivan Andreyevich Zhuk - Financial Administrator - Kodyma Rayon
1st Deputy - Maxim Sukovatiy
Head of Polyclinics - Anatoliy Pasiva

Self -Financing Hospital - Odessa

DrAnatoliy .Shubin - Head Doctor
Ms. Galena Petrova - Chief Economist
Ms. Ivina - Chief Accountant

Family Health Center - Odessa

Valentina Bespoyasnaya - Head Doctor
Liudmila Molochkova - Chief Economist

Odessa Oblast Health Administration

Dr. Alexandr Dmitriyevich Karvetskiy- Oblast Administrator
Dr. Akim Izrailievich Litvak- Oblast Administration Health Advisor
Tatyana Nechipurenko - Oblast Economist

Odessa Municipal Health Administration

Dr. Nikolay Viktorovich Ivanov
Dr. Peter Grigoryevich Lyapko -Municipal Economist and Statistician
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Annemarie Wouters, Ph.D., Abt Associates Inc. - Status only
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George Purvis, Contract Consultant
Roman Ponos, Financial Director- ZRP Ukraine
Yelena Truhan - IDS Office Manager- Kiev
Victor Omel'chenko. - ZRP Medical Consultant - Kiev

ANNEX VI

Daily Log

Saturday 6/8/96 -Left New York at 0930

Sunday 6/9/96 -Arrived Odessa in evening 1800

Monday 6/10/96 - Met with Wittenberg and reviewed workplan. Set goals and weekly working protocols. Updated initial workplan and began arrangements for initial meetings. Met with translator/interpreter/driver/office staff. Arranged for TDY apartment.

Tuesday 6/11/96 -Prepared data collection package for 3 hospitals for budgeting and cost accounting programs. Sent package for translation. Met with Genrick (software development expert) and discussed project, immediate needs, and outlined short term processing requirements. Began development of hospital worksheet designed to define major strategic issues and their respective priorities. Moved into TDY in evening. Met Mr. and Mrs. Mouse in kitchen. Agreed to share accommodation.

Wednesday 6/12/96 -Completed hospital strategic issue worksheet. Reviewed with Wittenberg. Met with Jennifer Wittenberg and discussed opportunities to report on project activities. Spent afternoon at Municipal Hospital #10 working with senior management staff on organizing and defining project steps and goals. Wittenberg advised Kodyma Head Doctor would be absent for approximately one to two months.

Thursday 6/13/96 -Worked with Genrick on detailed design of budget software. Divided initial task into three (3) phases to provide for immediate value to the project. Began trip report. Drafted a training outline of the performance management model, including the approach, method, and critical path steps. This will later be folded into the "How-to" manual. Met with Valentina Bespoyasnaya - Head of the Family Health Center of Odessa and discussed her cost accounting needs, her progress since the training session in February, and appropriate next steps. Chose a mutually acceptable course of action.

Friday 6/14/96 -Spent half day at Odessa Oblast Hospital. Met with senior staff and arranged follow-up meeting. Visit very successful and ZRP was asked for assistance by Head Doctor related to the Task at hand. Outlined "How-To" manual. Assisted translator with Performance Management terminology. Updated trip report. Finished performance management model outline. Updated Wittenberg on progress to date - next steps.

Saturday 6/15/96 -Attended to food shopping, laundry, etc. Discussed work agenda with Wittenberg for coming week. Reviewed progress with J. Lissfelt for dissemination value.

Sunday 6/16/96 -Updated workplan progress to date. Began interim report format. Updated trip report. Continued work on performance management most of afternoon and early evening. Russian elections today.

Monday 6/17/96 - Identified framework for strategic priorities in early morning. Worked at Municipal Hospital #10 with Wittenberg all morning into early afternoon. Identified target departments for decentralized budgets, cost accounting, performance management with accompanying automation effort. (Urology and Gastroenterology). Chief Economist Koval tasked to collect financial data on hospital and polyclinics. He failed to produce initial data after first meeting. Met with Chief of Polyclinic in afternoon and identified diagnostic area (a revenue generating department) as target department for improved financial management and respective automation effort where appropriate. Met with Genrick in late afternoon to further define and design appropriate pragmatic software tools. New driver took me back to TDY apartment and got lost en route.

Tuesday 6/18/96 - Met with senior management team of Oblast Hospital including Chief Doctor, Chief Economist, Chief of Inpatients, Chief of Surgery, Chief of Outpatients all morning. Defined target departments, provided training on automation effort, identified key strategic (organizational) issues and facilitated the setting of the relative priority of each strategic issue. Meeting was viewed by all as very constructive and valuable. Met with Chief economist afterwards and requested data collection of essential financial information. Agreed to decentralize budgets, provide essential cost accounting information, and define performance reporting in Admissions, Surgery, and the Biochemistry Laboratory.

Wednesday 6/19/96 -Left Odessa at 0730 for Kodyma with Wittenberg. Arrived in Kodyma at 1220. Met with First Deputy, Chief Economist, Chief Accountant, Chief Surgeon, Maternity Department Head, Pediatric department Head, and Polyclinic Head. Head Doctor was not in town. Else/Wittenberg identified 3 or 4 areas where financial assistance might be appropriate/useful at the departmental/functional level. Top choices were in the accounting processes and the maternity department. The accounting process for closing monthly books takes 10 people 15 days or 150 man-day. Looking to automate this function. Evening spent with Senior Management team.

Thursday 6/20/96 - Shared primitive "hotel-room" previous night with six persistent beetles and a loud rooster. Follow-on morning meeting with First Deputy at 0800. Left for Odessa at 0945. Arrived at Odessa ZdravReform office at 1340. Met with Genrick at 1400 to 1645 and honed design of software for decentralizing budgets.

Friday 6/21/96 -Met with Municipal Hospital #10 in morning (Koval) and he failed to produce any of the requested data. Data that was presented was incorrect and with many blanks. Koval seemed uninterested in project. Requested assistance from Chief Accountant. Did obtain useful data regarding key operational indicators. Advised Wittenberg. Met with Oblast Hospital team all afternoon and obtained 90% of what was requested to date. An excellent team effort. They are enthusiastic and quite willing to work. Driver was stopped by National Police and a 30 minute search for weapons was conducted with a total search of car and belongings. Interim (temporary) driver then stopped for doing 140 KPH on a 60 KPH roadway. Made it back to office at 1810. Met with Purvis in evening. Update Wittenberg on weeks progress and open issues. Met with Boris Uspensky in evening at TDY and discussed automation efforts. Counseled driver on "reasonable" driving habits.

Saturday 6/22/96 -Completed interim report. Took most of the day to accomplish this. Then worked on defining cost accounting software packages for each of the three hospitals.

Sunday 6/23/96 -Visited market. Read.

Monday 6/24/96 -Visited Hospital #10 in morning and collected more data from Koval. Met with Rayon Accountant and outlined what was required. Met with enrich in afternoon and revised software.

Tuesday 6/25/96 -Visited Odessa Clinical Hospital most of day working with Chief Accountant and Chief Economist. Defined allocation methods for selected articles and overhead departments.

Wednesday 6/26/96 -Followed up at Hospital #10 in morning and met with Chief of Polyclinic (Grigory) in afternoon. Thursday trip to Kodyma has been canceled due to Head Doctor.

Thursday 6/27/96 - Met with Grigory in morning and Genrick most of afternoon. Created Phase II outline for Genrick. Worked with Tom Wittenberg on deliverables.

Friday 6/28/96 -Worked at Oblast Clinical Hospital most of day. Returned and met with Genrick in late afternoon and early evening. Took Lissfelt to IDS site as observer.

Saturday 6/29/96 -Worked with Wittenberg in Office. Entered data into computer system for decentralized budget. Began first pass at costs for Odessa Clinical Hospital. Updated Trip report. Issued revised schedule for weeks activities.

Sunday 6/30/96 -Began interim Report #2 AT TDY during morning. Took afternoon off for a walk in and around Odessa.

Monday 7/1/96 - Met with Genrick in morning, and Municipal Hospital #10 in afternoon for the never ending collection of data and training. Updated Tom Wittenberg on open issues at Hospital #10.

Tuesday 7/2/96 - Left for Kodyma in early AM and returned in very late PM. Met with Head Doctor and staff, defined work, collected data, set objectives, started budget decentralization.

Wednesday 7/3/96 -Met with Genrick in morning and Grigory at Municipal hospital #10 in afternoon. Met with Wittenberg in evening.

Thursday 7/4/96 -Went to Oblast Clinical hospital for the day. Updated Head Doctor on progress. Wittenberg accompanied me. Met with accounting, economic, and senior management staff. Late so returned direct to TDY.

Friday 7/5/96 -Office closed so got keys and worked in office all day updating work to date and preparing for next week.

Saturday 7/6/96 -In morning updated trip report, redefined Kodyma costs and prepared for Oblast on Monday. In late afternoon went for walk.

Sunday 7/7/96 -Produced Interim Report #2 all day.

Monday 7/8/96 -Met with Genrick in morning, trained Oblast staff in early afternoon, and visited Grigory at Polyclinic in late afternoon to review decentralized budgets and departmental costs. He did not show up again. Rolled out current work to Family Health Center, instead.

Tuesday 7/9/96 -Met with Genrick in morning. Worked in office preparing for week-end departure, next steps for Phase II. Visited Oblast in afternoon.

Wednesday 7/10/96 - Met with Head Doctor from Kodyma all afternoon in Office. Updated decentralized budgets and allocation tables. Met with Genrick in late afternoon. Worked with Family Health Center in afternoon.

Thursday 7/11/96 -Trained at Oblast in morning. Rolled-out decentralized budgeting to Self-Financing Clinic. Visited Municipal Hospital #10 in afternoon and updated decentralized budgets.

Friday 7/12/96 - Updated Wittenberg in morning. Prepared and printed reports in afternoon. Went to Airport. Departed for Amsterdam.

Sunday 8/4/96- Arrived in Odessa in the evening.

Monday 8/5/96- Met with Wittenberg in morning to update progress since departure in July. Arranged schedules for week. Prepared agenda for weeks meetings.

Tuesday 8/6/96- Met with Municipal Hospital #10 Senior Management Team all morning. Assessed progress regarding the small automation effort with the computer programmer in early afternoon, and trained primary user from Hospital #10 (Oksana) in late afternoon.

Wednesday 8/7/96- Met with Municipal Health Administrator , Dr. Ivanov, in the morning; Evaluated and trained at Hospital #10 in early afternoon regarding the costs for seven departments within the polyclinic, and Trained with Oksana from Hospital #10 in late afternoon.

Thursday 8/8/96- Rolled-out and trained at the Self-financing Clinic all morning. Trained at Hospital 10 all afternoon regarding cost accounting an decentralized budgeting.

Friday 8/9/96- Wrote more on the "How to" computer manual all morning. Met with Dr. Litvak from the Oblast Health Authority in afternoon as well as the Municipal Health Authority. Collected global budget data from each authority.

Saturday 8/10/96- Worked in office all day with ZRP staff entering data from the Oblast and Municipal authorities in preparation for a roundtable presentation as to the role of budgeting and cost accounting information at the regional and municipal authority levels.

Sunday 8/11/96- Worked in TDY all day. Began trip report. Updated "How-To" manual. Wrote a Case Study for using automation for strengthening financial management capabilities.

Monday 8/12/96- Met with Municipal Authority Data Systems representative (Diachkin) n morning and reviewed the role of current field work in their automation scheme. Trained Municipal Hospital #10 in afternoon and ended day with short meeting with Genrick to go over software revisions.

Tuesday 8/13/96- Trained at Oblast Hospital all morning on Budgeting, performance management, and cost accounting calculations. Trained Municipal hospital #10 in late afternoon.

Wednesday 8/14/96- Met with Grigory at Municipal Hospital #10 I morning. Reviewed progress, cost accounting data. Met with Michelle from AID in afternoon. Discussed current task. Met with Oblast Clinical Hospital Chief Accountant and Chief Economist in late afternoon. Ended day with meeting with Municipal Authority going over next steps of applying financial principals in an automated environment.

Thursday 8/15/96 -Met with Municipal Hospital #10 (Grigory) in morning and reviewed progress to date. provided training on use and application of performance indicators.

Friday 8/16/96 - Worked in Kodyma all day. Delivered Tom Wittenberg's rental computer. Trained Head Doctor on applying performance indicators. Left at 0630 and returned at 2200.

Saturday 8/17/96- Wrote "How-To" manual most of day in TDY. Visited the USS LaSalle which is in harbor in the evening. Nice to see Yankees!

Sunday 8/18/96- Wrote "How-To" Manual most of day in TDY.

Monday 8/19/96- Updated Trip Report in Morning. Met with Gennrick in afternoon and honed the performance management system

Tuesday 8/20/96- At Oblast Clinical Hospital most of day. Met with Head Doctor and Senior Staff. Reviewed process and next steps. Provided training on Performance Management indicators.

Wednesday 8/21/96- Worked with Oblast Clinical Hospital (Sasha) most of the day insuring their capability to maintain the software system and costing data. Karvetskiy meeting was canceled as he was in Kiev (still).

Thursday 8/22/96- Karvetskiy meeting was canceled as he was in Kiev (still). Was at Oblast all day training staff on all aspects of the field work. met with head doctor and provided training on Performance indicator system.

Friday 8/23/96- Worked in office with Municipal Hospital #10 and Oblast Clinical Hospital reviewing all aspects of the field work to date.

Saturday 8/24/96- Worked in TDY on Trip Report all day

Sunday 8/25/96- Worked in TDY on Trip Report in morning

Monday 8/26/96- Worked in TDY on “How-To” manual all day

Tuesday 8/27/96- Final Presentation and training at Oblast Clinical Hospital. Met with Genrick in late afternoon.

Wednesday 8/28/96- Final Presentation and training at Municipal #10 Hospital. Training with Municipal Hospital #10 in Office in afternoon. Met with Oblast health Care Administrator in late afternoon.

Thursday 8/29/96- Final Presentation and training at Kodyma Hospital

Friday 8/30/96- Trip report update. Debriefing with Tom Wittenberg. Training with Oblast and Municipal Hospital in morning in office. Departed for Amsterdam in evening.